**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor's Name and Address:<br>DR. SAM FINO<br>14721 COIT RD<br>DALLAS TX 75254 | MFDR Tracking #: M4-11-1137-01 |
| | DWC Claim #: |
| | Injured Employee: |
| Respondent Name and Box #:<br>TEXAS MUTUAL INSURANCE CO<br>REP BOX: 54 | Date of Injury: |
| | Employer Name: |
| | Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "have paid in past before code change want payment."
Principal Documentation:
Total Amount Sought $360.00

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Texas Mutual Insurance Company reviewed the requestor's TWCC-60 packet and has concluded to pay the disputed service."

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 07/07/10 | 16, 193, 225, 732, 18, 224, 878, 891 | G0431-QW – Pain Management Drug Screen | $360.00 | $0.00 |
| **Total Due:** | | | | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. According to the Respondents position summary, the insurance carrier has concluded to pay the disputed service.

3. The Respondent has submitted an EOB along with a file copy of check number 10624292 showing payment was made in the amount of $360.00 plus $3.86 in interest.

4. Therefore, in accordance with 133.307(e)(3)(A) the Division has determined that the Requestor has been reimbursed and a dispute no longer exists.

For the reason stated above, the division finds that that reimbursement is not due. As a result, the amount ordered is $0.00.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

| | | |
|---|---|---|
| | | March 3, 2011 |
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |

## PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**